(Organization)

Drop Down Box
(Date)

SUBJECT: Medical Treatment/Hospitalization of National Guard Personnel at Ellsworth Air Force Base Hospital

Commander
U.S. Air Force Hospital
Ellsworth Air Force Base
Rapid City, South Dakota 57706-5000

1. Request the individual named below be admitted to your hospital for treatment under the provisions of paragraph 7, AFR 168-6.

a. _____
(Name) (Grade) (SSN)

_____
(Organization) (Home Station)

b. Individual is a member of the South Dakota Army National Guard not on extended active duty.

c. Type of duty being performed (Check one): Check Box options

(1) _____ Active duty for training.

(2) _____ Inactive duty for training.

d. Inclusive dates of training: _____

e. If injured, give brief statement of circumstances: _____

_____

_____

2. Individual is entitled to treatment under the provision of Title 32 (Annotated) USC, Sections 502 and 503.

Electronic Signature Box

SDNG Form 2[redacted] (29 June 92)

Initial Incident Report Abbreviated

Complete the following information AS SOON AS POSSIBLE
Unit completes POC before placing in Log Book

Unit POC _____ Phone: _____
Squad Leader _____ Phone: _____

Commander _____

1. Name & Rank of person reporting the information:

_____

a. Phone Number:(at scene) _____ b. Date: Drop down Box

2. Unit: _____

3. Incident Information: a. Date and time Drop Down Box

b. Location: City/Post: _____ State: Drop Down Box
c. Location (distance from town, coordinates highway & or mile marker):

_____

_____

4. Persons involved & medical status: check box
Military ☐ _____
Civilian ☐ _____

5. Type of incident (check applicable selections) Check Box

☐ Army Vehicle	☐ Combat Vehicle	☐ GSA Vehicle
☐ Civilian Vehicle	☐ Equipment	☐ Explosives
☐ Fire	☐ Facility	☐ Aircraft

Remarks if other: _____

6. Narrative of Accident (How it happened):

_____

_____

_____

_____

SDNG Form 3A-AB (1 April 01)
(8 1/2 X 5 1/2 CARD STOCK ONLY)

Initial Incident Report Abbreviated

Complete the following information AS SOON AS POSSIBLE
Unit completes POC before placing in Log Book

Unit POC _____ Phone: _____
Squad Leader _____ Phone: _____

Commander _____

1. Name & Rank of person reporting the information:

_____

a. Phone Number:(at scene) _____ b. Date: Drop Down Box

2. Unit: _____

3. Incident Information: a. Date and time _____

b. Location: City/Post: _____ State: Drop Down Box
c. Location (distance from town, coordinates highway & or mile marker):

_____

_____

4. Persons involved & medical status: Check box option
Military ☐ _____
Civilian ☐ _____

5. Type of incident (check applicable selections) Check box option on all more than one selection

☐ Army Vehicle	☐ Combat Vehicle	☐ GSA Vehicle
☐ Civilian Vehicle	☐ Equipment	☐ Explosives
☐ Fire	☐ Facility	☐ Aircraft

Remarks if other: _____

6. Narrative of Accident (How it happened):

_____

_____

_____

_____

SDNG Form 3A-AB (1 April 01)
(8 1/2 X 5 1/2 CARD STOCK)

EMERGENCY TREATMENT AND INCIDENT NOTIFICATION

NOTIFICATION WILL BE REPORTED WITHIN 24 HOURS

TO: [redacted]

SDSSO Log/
Control Number _____

UNIT INFORMATION : **UIC:** _____ **Reporting Date:** Drop Down Box

_____ _____

Unit **Home Station or City**

_____ _____

Unit Point of Contact **Phone number**

INCIDENT INFORMATION: Date & Time of Incident: Drop Down Boxes

a. City/Post: _ b. State: _ c. Zip Code:

Narrative: (explain how and what happened)

INJURY INFORMATION (When multiple injuries occur complete one SDNG Form 3 for each injured person.)

Check Box option

Personnel involved: ☐ Military: ☐ Civilian: ☐ Technician: ☐ Other

(Rank/Grade) (NAME-LAST, FIRST, MI) (SSN)

(Describe the Medical Treatment Received)

(Doctor Administering Treatment)

(Hospital/Clinic /TMC where individual was treated)

Check Box option

Duty Status: ☐ IDT ☐ ADSW ☐ AT ☐ AGR ☐ Other

Check Box option

Status upon Return: ☐ Off Duty ☐ Light Duty ☐ Return to duty

Drop Down Box

Return date and time

Check Box option

Incapacitation Pay Involved? ☐ Yes ☐ No

Check Box option

Further Treatment Needed: ☐ Yes ☐ No

Check Box option

Type of LOD Required: ☐ Administrative ☐ Formal ☐ Informal ☐ None

Remarks: _____

EQUIPMENT/VEHICLE INFORMATION: (Check applicable equipment or vehicles involved) Check Box Available for one or more Select

☐ Army Vehicle ☐ Combat Vehicle ☐ GSA Vehicle ☐ Civilian Vehicle

☐ Weapons ☐ Radio/Communication ☐ Explosives ☐ Construction

Remarks * (Model number of equipment)_

FIRE EXTINGUISHER RECORD

As required by NFPA 10 paragraph 4-3.4 and 4-4.4 dated 1998

Fire extinguisher/vehicle number: Location:

Serial Number: Type: Rating:

Date Annual Maintenance Conducted	6 Year Recharge (when required) Date due	Date conducted

Hydrostatic Cylinder Inspection NFPA 10 paragraph 5-2

Date Conducted	Next Scheduled Date	Date Conducted	Next Scheduled Date

Remarks

SD Form 3-420 dtd 1 Feb 2000

Safety Incident Investigation Report

Report Date: _____ **SDSSO Log Number:** _____

Accountable Unit: _____ Phone: _____

Unit Point of Contact: _____ Phone: _____

Incident Information

UIC: _____ Incident Date: _____ Day/Night: _____ Time: _____

Location of incident(closest city, post, road, landmark, GPS): _____

Description on accident(who, what, when, and where):

CHECK THESE AREAS (mark for *YES*) Check BOX more than one Select

METL Task involved?	☐	Was SOP Followed?	☐	Does SOP Address Safety	☐
Was Risk Management done?	☐	Risk Management Documented?	☐	Risk Acceptance level followed?	☐
Heat injury	☐	Injury to more than one	☐	Overnight treatment needed	☐
License outdated?	☐	Was PMCS conducted?	☐	Vehicle properly dispatched?	☐
Civilians involved	☐	Refueling Operations	☐	M939 Series Truck involved	☐
Blocking & bracing	☐	Weapons involved?	☐	Ammunition & Explosives	☐

Incident Failures: Incident Failures as determined by investigator: Check the appropriate blocks and describe your determination of the failure(s) the best that you can. Check Box more than one Select

Individual failure	☐	Leader Failure	☐	Standards Failure	☐
Support Failure	☐	Material Failure	☐	Other	☐

Recommended Actions: The recommended actions that should be taken be the accountable unit: (check if appropriate) Check Box more than one Select

Individual failure	☐	Leader failure	☐	Standards failure	☐
Support failure	☐	Material failure	☐	Unit	☐
Command	☐	Support	☐	Other	☐

Safety Accident Investigator: _____ Title: _____

Unit: _____ Phone: _____

INDIVIDUAL RECORD OF WEIGHT CONTROL PROGRESS/COUNSELING

(TO BE USED FOR OVERWEIGHT PERSONNEL ONLY)

(NAME & SSN OF UNIT MEMBER)	(DATE & PLACE OF WEIGHT REDUCTION PROGRAM)
(DATE OF NEXT PROGRESS EVALUATION)	(PRESCRIBED WEIGHT LOSS PER MONTH)
(NUMBER OF MONTHS AUTHORIZED ON PROGRAM)	(DATE INDIVIDUAL MUST BE OFF PROGRAM WITH SATISFACTORY PROGRESS)

DATE: MONTH / YEAR	CURRENT HEIGHT/WEIGHT		TOTAL POUNDS GAINED OR LOST SINCE LAST MONTH	SIGNATURE OF PERSON WHO CHECKED WEIGHT OF INDIVIDUAL	SIGNATURE OF UNIT COMMANDER AT TIME OF COUNSELING THE INDIVIDUAL	INDIVIDUAL'S SIGNATURE ACKNOWLEDGING COUNSELING
	HEIGHT	WEIGHT				
Drop Down Box	Drop Down Box	Drop Down Box	Drop Down Box	Electronic Signature	Electronic Signature	Electronic Signature

REMARKS:

DOB: _____ AGE: Drop Down Box

ALLOWABLE HEIGHT: Drop Down Box

ALLOWABLE WEIGHT: Drop Down Box

SDNG Form 4-F (29 Jun 92)

(Unit Letterhead)

Drop Down Box
(Date)

SUBJECT: Order to: _____
(Type of Training Assembly)

The following named selected individual(s) are hereby ordered to attend a training assembly in proper uniform for not less than 4 hours for each training assembly on the date(s) indicated below:

GRADE	NAME	SSN	DATE/TIME	LOCATION	# OF ATA
Drop Down Box			Drop Down Box		

Nature of Training: (use reverse side if necessary) (Code ____)

_____

_____

_____

****

Certificate Drop Down Box
(Date)

This is to certify that the above listed personnel performed the training.

Electronic Signature
(Signature of Certification/Verification Officer)

SDNG Form 5 (29 Jun 92)

REQUEST FOR TRAINING/TECHNICAL ASSISTANCE

TO: Drop Down Box

THRU: TAG SDARNG-POTO-T APPROVED/DISAPPROVED Electronic Signature
Signature/Date

THRU: _____ Drop Down Box APPROVED/DISAPPROVED Electronic Signature
Gp or Bde Designation Signature/Date

THRU: _____ Drop Down Box APPROVED/DISAPPROVED Electronic Signature
Bn Designation Signature/Date

FROM: _____ [redacted] COMMANDER-REQUESTING UNIT Electronic Signature
Unit Designation Signature/Date

Request the following support to be provided:

_____ _____
(UNIT TO BE SUPPORTED) (LOCATION OF ACTUAL SUPPORT)

Drop Down Box _____
(DATE/TIME SUPPORT REQUIRED) (NUMBER OF TROOPS/CREWS/UNITS/LEADERS TO BE INSTRUCTED)

TYPE SUPPORT: _____

EQUIPMENT REQUIRED FROM SUPPORTING AGENCY: _____

REMARKS: _____

POC: _____
(NAME) (TITLE) (TELEPHONE NUMBER)

IF PREVIOUS CONTACT WAS MADE, WITH WHOM WAS IT MADE? _____

SUBMIT IN ORIGINAL COPY

SDNG Form 8 (29 Jun 92)

APPLICATION FOR ASSIGNMENT
TO THE
INACTIVE NATIONAL GUARD

Drop Down Box
(Date)

SUBJECT: Application for Assignment to the Inactive National Guard (ING)

TO: The Adjutant General
State of South Dakota
2823 West Main Street
Rapid City, South Dakota 57702-8186

1. I, _____, _____ hereby
(Rank and Full Name) (SSAN)
apply for assignment to the ING of South Dakota.

2. I will be available for immediate involuntary mobilization with my unit of attachment of the South Dakota National Guard, in time of Federal or State emergency.

3. My permanent address is _____.

4. I will report any change of address to my unit of attachment within 30 days and that I will report to my unit of attachment annually during the announced muster day.

5. This assignment is requested because of: (See para 2-3 or 3-3, NGR 614-1)

---

6. I hereby acknowledge that I have had explained how transferring to the ING affects my bonus participation. Also, upon return to active status, I must occupy an authorized MTOE/MTDA vacancy appropriate to my grade.

7. Unit must attach substantiating documents concerning reasons for transfer to the ING.

Electronic Signature
(Signature)

_____
(Typed Name)

[redacted]
(Rank)

SDNG Form 9 (29 Jun 92).

FOR USE SEE NGR 614-1

SOUTH DAKOTA ARMY NATIONAL GUARD

VISITOR REGISTER

UNIT: _____ STATION: _____

Name	Grade	Organization	Purpose of Visit	Date

SDNG Form 10 (29 Jun 92)

SCREENING PHYSICAL EXAMINATION FOR ARMY RECRUITMENT
"SPEAR WORKSHEET"

TO: _____ (Reception Station) FROM: _____ (Unit of Assignment)

PART 1

1. Applicant's Name	2. Date of Birth	3. SSN	4. Date of SPEAR

PART 2

APPLICANT'S MEDICAL HISTORY

Have you ever had (or do you now have): (Write YES or NO) Check Box optic Yes No For All in this Section

____A loss of hearing in either ear?
____Injury or illness involving your eyes?
____A Painful or "trick" joint?
____Fallen Arches (flat feet)?
____The loss of any finger or toe?
____Trouble breathing to include asthma?
____Difficulty standing for long periods of time?
____A loss of normal movement in any limb or joint?
____Epilepsy of fits?
____A nervous condition?
____Back trouble?
____Any Surgery or operation?
____Any illness or injury requiring repeated treatment by a doctor?
____To take any medicine?
____Any addiction to drugs or alcohol?
____Any period of hospitalization?
____A doctor recommend any surgery?

Explain all YES answers

_____
_____
_____

APPENDIX A, AR 40-501

Height	Minimum weight (lbs)	MALES MAXIMUM ONLY				
		16-20 years	21-30 years	31-40 years	41 years and over	
60 ..	100	150	163	162	167	150
61 ..	102	163	168	167	162	155
62 .	103	168	174	173	168	160
63 ..	104	174	180	178	173	165
64 ..	105	179	185	184	178	171
65 ..	106	186	191	190	184	176
66 ..	107	191	197	196	190	182
67 ..	111	197	203	202	196	187
68 ..	116	203	209	208	202	193
69 ..	119	209	215	214	208	198
70 ..	123	215	222	220	214	204
71 ..	127	221	228	227	220	210
72 ..	131	227	234	233	226	216
73 ..	135	233	241	240	233	222
74 ..	139	240	248	246	239	228
75 ..	143	246	254	253	246	234
76 ..	147	253	261	260	252	241
77 ..	151	260	268	266	259	247
78 ..	155	267	275	273	265	254
*79	160	273	282	281	273	260
*80	165	280	289	288	279	267

WITHIN 72 HOURS PART 3

PHYSICAL EXAMINATION BY COMMANDER:

Measured Height: _____

Measured Weight: _____ ____MAX
____MIN

Check Box
Vision in both eyes: Yes ☐ No ☐

Check Box
Does applicant state he/she has normal color vision? Yes ☐ No ☐

SDNG Form 12 (29 Jun 92)

PART 4

Individual will indicate receipt of the below listed items by initialing in the blank preceding the listed item: Check Box of more than one Selection

a. _____ Personnel Records (DA Form 201)

b. _____ Health Records (DD Form 3444 Series with Documents)

c. _____ Orders

d. _____ Clothing and Clothing Records (Inventoried prior to departure)

e. _____ Finance Records (DA Form 3716 with Documents)

Have you had any recent involvement with law enforcement agencies and/or do you have any court appearances pending since your enlistment in the ARNG_____.

Explain if you have answered yes: _____

_____

_____

_____..

COUNSELING STATEMENT

I have been counseled concerning the need for a "regulation" haircut, requirment for some money (approximately $40.00) for immediate expenses and the new physical training test requirements outlined in FM 21-20.

Electronic Signature
(Commander/Representative Signature)

_____
(Individual Trainee Signature)

PART 5

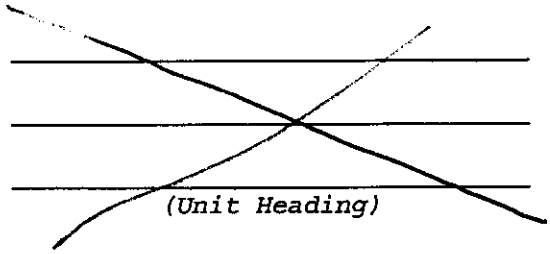
REMARKS:

PART 6

PRIVACY ACT STATEMENT

AUTHORITY: Collection of this information is authorized by sections 505,510 and 3012 of Title 10 of the US Code.
PRINCIPAL PURPOSES: To physically screen applicants to identify possible disqualifying defects before AFEES processing.
ROUTINE USES: (1) prepare applicant for medical processing by insuring possession of documentation, eye glasses, etc. (2) provide information for AFEES medical officer to base determination of physical qualification.
EFFECTS OF NOT PROVIDING INFORMATION: The disclosure of this information is voluntary. Failure to provide the information, however, will result in discontinuance of processing.

U.S. GOVERNMENT PRINTING OFFICE 827-841



SUBJECT: Authorization to Perform Equivalent Training

Drop Down BOX
(Date)

_____

(Indiv Grade, Name & SSN)

AUTHORIZATION

1. You are authorized to perform EQUIVALENT TRAINING as indicated below.
2. Place: _____
3. Type duty to be performed: _____
4. Period (Date/Hours): _____
5. Additional Instr: Above Duty Performed ILO scheduled Assy(s) _____

_____

Electronic Signature
(Signature Unit Commander)

UNIT: _____ **CERTIFICATE** _____ DATE: Drop Down BOX

1. This is to certify that the above individual performed Equivalent Training in proper uniform on dates specified above, in lieu of the scheduled training assembly(s) indicated in the above authorization.

GRADE	NAME	SSN	SCHEDULED ASSY DATE	DATE ET WAS PERFORMED

2. The following training was received by the individual(s) listed above:

Electronic Signature
(Signature Unit Cdr, Officer or Warrant Officer)

SDNG Form 15 (1 AUG 00) (Previous editions are obsolete)

PHYSICIAN'S STATEMENT

I have examined and found that _____ _____
(SSN) (Rank)

_____
NAME: (Last, First, Middle Initial)

_____ **of the**
(Unit and Address)

South Dakota Army National Guard, was disabled for the performance of his military duties during the period: From _____ To _____

DIAGNOSIS

inclusive, due to _____

_____

_____

_____

It is expected that the individual will return to normal military duty on Drop Down Box
(Date)

_____

_____

_____

Electronic Signature
(Signature,Name,Title and Address of Attending Physician)

DISTRIBUTION:
1-TAGO SD
1-USP&FO SD
1-201 file

SDNG Form 18 (1 OCT 00)

ATTRITION MANAGEMENT REVIEW
BOARD ACTION AND RECOMMENDATIONS
Chapter 4, NGB Pam 601-280)

Part I

The attached request for separation, prior to scheduled ETS, is forwarded for your recommendation. Enter your comments, if any, check your recommendation, and forward to the next member at your earliest convenience.

NAME OF INDIVIDUAL: _____

Check Box Option Check Box Option
SEX: M ☐ F ☐ Minority group designator: Black ☐ Hispanic ☐ Oriental ☐

CURRENT UNIT: _____

REASON FOR REQUEST: _____ Para _____ NGR 600-200

Check Box Option
Unit commander's recommendation: Approve ☐ Disapprove ☐ Other ☐

Check Box Option
Service Member is ☐ is not ☐ eligible for assignment to the ING.

Inclosures: Check Box Option
- ☐ Service member's request or ☐ Unit commander's request
- ☐ Report of investigation by
- ☐ State (official) Personnel File
- ☐ Other

Signature Electronic Signature Title

Part II

I have reviewed the information provided and recommend: [redacted]
Check Box option Check Box Option

MEMBER	FOR DISCHARGE		ASSIGN TO ING		INITIALS	DATE
	APPROVE	DISAPPROVE	YES	NO		Drop Down Box
DCSPR	☐	☐	☐	☐		
RRM	☐	☐	☐	☐		
CSM	☐	☐	☐	☐		

Part III

TO:State DCSPR FROM: Chairperson Attrition Management Review Board Date: Drop Down Box

Check Box option

☐ Discharge approved ☐ Discharge denied ☐ Assign to the ING

SIGNATURE Electronic Signature CHAIRPERSON

SDNG FORM 20 (1 OCT 00)

TRAIN[illegible] SCHEDULE

UNIT/SECTION/SQUAD:	ARTEP/POI:	DATE: Drop Down Box

DAY, DATE DRILL NR.	TIME FROM TO BE	PERSONNEL TO TRAINED	TASK/ ACTIVITY	REFERENCE	TRAINER	LOCATION	UNIFORM & EQUIP REMARKS

SDNG Form 23[redacted]
(1 JUNE 01)

All members are herby ordered to attend all periods of training shown:

[redacted]

Approved by: Electronic Signature

COMMANDER: Electronic Signature

TRAINING OUTLINE

UNIT/SECTION/INDIVIDUAL TO BE TRAINED _____

_____ DATE/TIME: Drop Down Box

TRAINERS _____

	TRAINING STATEMENT
	CAUTION STATEMENT
	PRETEST
	ORIENTATION STATEMENT
	DEMONSTRATION
	TASK STEPS
	PRACTICE
	PERFORMANCE TEST
	REQUIRED RESOURCES

SDNG Form 23-1 (1 JUN 01)

(Instructions for use on reverse side)

TRAINING OUTLINE

Write notes to be sure the following items are covered:

TRAINING STATEMENT:	Based on training objectives, state task and how well.
CAUTION STATEMENT:	Security classification, troop safety, care of equipment.
PRETEST:	Ask soldiers if they are ready. Prepare conditions. State task. Observe standards. Critique performance.
ORIENTATION STATEMENT:	Preview what, why, and how.
DEMONSTRATION:	Show how.
TASK STEPS:	Hands-on, by-the-numbers walk-through.
PRACTICE:	On-the-spot corrections.
PERFORMANCE TEST:	Same as pretest. Critique after test.

WORK PLAN

UNIT/SECTION: _____ LOCATION: _____ DATE: Drop Down Box

Specific Action/ Work to be Accomplished	Hours Estimated	Individual(s) assigned to Training/Work	Supervisor/ Trainer	Accomplished		Remarks: (Evaluation, Work, Incomplete, Etc.
				YES	NO	

Completed By: Electronic Signature
Approved By: Electronic Signature

SD ~~ZS 2 dtd 1 NOV 98~~

SDSS Form 23-2 dtd 1 NOV 98